MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

# CERTIFICATE OF DEATH

11093

Reg. Dist. No. 182

**1. PLACE OF DEATH:**

County Harford

City or town Benson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Harford

City or town Benson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Mary Elizabeth Archer

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | W |

6.(b) Name of husband or wife George Archer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 18 - 1854

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 92 | | | ..... hrs. ..... min. |

9. Birthplace Rockeville Balto. Co., Md

(Town, county, and state)

10. Usual occupation ✓

11. Industry or business

FATHER

12. Name Wells Clayton

13. Birthplace Md

MOTHER

14. Maiden name Mary E. Watkins

15. Birthplace Md

16. Informant Walter H Archer

Address Benson, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26/46 (month) (day) (year)

Cemetery or crematory Mountain Christian

Location Joppa, Harford Co., Md.

18. Funeral director Dean & Foster

Address Bel Air Md.

19. 11/25 1946 Priscilla Foxwood

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1946, at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1923 to Nov 1946 and that I last saw h alive on Nov 20 1946

| Immediate cause of death | DURATION |
|---|---|
| Myocardial Failure | |
| Due to Age | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C M Hopkins M. D. or other

Address Bel Air Md Date signed Nov 26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25-a)

## CERTIFICATE OF DEATH

11094

Reg. Dist. No. 182.0

**1. PLACE OF DEATH:**
County Harford
~~City~~ or town Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Harford
~~City~~ or town Bel Air, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** MARY POSEY BROOKS

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife Harry M. Brooks
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 15 - 1884

8. AGE: Years 62 Months 5 Days 24 If less than one day hrs. min.

9. Birthplace York Co. Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name M. A. Posey
13. Birthplace York Co. Pa.

MOTHER
14. Maiden name Rebecca C. Wise
15. Birthplace York Co. Pa.

16. Informant Thos. H. Brooks
Address 1613 E. High St. Carlisle Pa.
17. Burial (Burial, cremation, or removal? Which?) Date thereof Nov. 12, 1946 (month) (day) (year)
Cemetery or crematory Friends Cemetery
Location Town Hill, Pa.
18. Funeral director Hubert P. Watkins
Address Delta, Pa.
19. 11/10 1946 Priscilla Forwood
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1946, at 10:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7, 1946, to November 9, 1946
and that I last saw h[illegible] alive on November 9, 1946

| | DURATION |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | 2 days |
| Due to: Arterial Hypertension | unknown |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert A. Barthel MD
M. D. or other
Address Forest Hill, Md. Date signed Nov. 10, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the change of date of death is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70C)

FILM No. I 08 DEC 2 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 1095 184 21

**1. PLACE OF DEATH:**
County: Harford
City or town: Darlington Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

**3. (a) FULL NAME:** Ruth Ann Dawson

**3. (b) Social Security Number:** No

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 1, 1943
8. AGE: Years 3 Months 5 Days 6 If less than one day ..... hrs. ..... min.
9. Birthplace (Town, county, and state): Harford Co., Md.
10. Usual occupation: None
11. Industry or business: None
FATHER 12. Name: Harvey Dawson
FATHER 13. Birthplace: Harford Co. Md.
MOTHER 14. Maiden name: Helen Stern
MOTHER 15. Birthplace: Gark Co, Penna.
16. Informant: Harvey Dawson
Address: Darlington, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9 1946 (month) (day) (year)
Cemetery or crematory: Ascension Cem.
Location: Harford Co. Md.
18. Funeral director: H. S. Bailey
Address: Darlington Md.
19. Nov. 8, 1946 (Date rec'd by registrar) M. E. Kirk Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. Oct. 6, 1946 at 1:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

| | DURATION |
|---|---|
| Immediate cause of death: Fracture of Skull-Basal | |
| Due to: | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Oct. 6, 1946
Where did injury occur? (May) Dublin (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?): Public Road
Means of injury: Fell out of auto Injured at work? No

23. SIGNATURE: J. H. Lawrence M.D.
Dep. Medical Examiner M.D. or other
Address: Aberdeen, Md. Date signed Oct 7, 1946

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-1820 2-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

## CERTIFICATE OF DEATH

Reg. Dist. No. 11182

**1. PLACE OF DEATH:**

County: Harford Co. Md

City or town: Belair (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two weeks

Hospital, institution, or street address where death occurred: Harford Convalescent Home

How long in hospital or institution? Two weeks

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md County: Belair

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 5405 Park Heights Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** Giovannina Di Leonardi

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widow |

6.(b) Name of husband or wife: Francesco Di Leonardi

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 8, 1867

8. AGE: Years 79 | Months 1 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace: Italy (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER — 12. Name: Bartolomeo Zichittella

FATHER — 13. Birthplace: Italy

MOTHER — 14. Maiden name: Leonarda Scarpitta

MOTHER — 15. Birthplace: Italy

16. Informant: Albert Di Leonardi

Address: 3601 Harford Road

17. Entombment (Burial, cremation, or removal. Which?) Date thereof: Nov 25-46 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Balto Co.

18. Funeral director: Frank V. Pipitone

Address: 2818 E. Baltimore St.

19. 11/25 19.. XC D. W. Hedrick Registrar (Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 22 Nov. 1946 at 5:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.. to — 19..

and that I last saw h... alive on — 19..

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis ?? (Dead on my arrival). | ? |
| Due to: arteriosclerosis | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles Richardson Jr. M.D. M. D. or other

Address: Bel Air, Md Date signed 23 Nov. 46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1607)

## CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS OF

11097

Reg. Dist. No. 185-0

**1. PLACE OF DEATH:**

County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 hrs 35 Minutes

Hospital, Institution, or street address where death occurred:
Harford Memorial Hospital

How long in hospital or institution? 8 hrs 35 Min.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. Harford Memorial Hospital
(If rural, give LOCATION)

2.(a) If veteran, name war: [illegible] 2

**3.(a) FULL NAME** Baby Boy Firestone

**3.(b) Social Security Number** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W | Infant |

8.(b) Name of husband or wife: —

8.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): November 5, 1946

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | — | 8 hrs. 35 min. |

9. Birthplace: Havre de Grace, Harford, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Rees Firestone
13. Birthplace: Ohio

MOTHER
14. Maiden name: Lois Wishum
15. Birthplace: Alabama

16. Informant: Mr. Rees Firestone
Address: Edgewood Arsenal, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1946 (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Havre de Grace Md.

18. Funeral director: R. Madison Mitchell

Address: Havre de Grace, Md.

19. Nov. 6 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-6 1946, at 12:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-5 1946 to 11-6 1946 and that I last saw him alive on 11-6 1946

| Immediate cause of death | DURATION |
|---|---|
| Cerebral injury | |
| Due to: Difficult and prolonged labor | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dudley Phillips M.D.
M. D. or other

Address: Harford Mem. Hospt. Date signed 11-6-46

2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

WITHIN CORPORATE LIMITS OF

## CERTIFICATE OF DEATH

11098

Reg. Dist. No. 18-5

**1. PLACE OF DEATH:**
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 30 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
Street No. 77 N. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Nancy Garner

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6.(b) Name of husband ~~or wife~~ John W. Garner
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) September 14, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 2 | 16 | ...hrs. ...min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Alexander McCullough
13. Birthplace Harford Co., Md.
14. Maiden name Mary Jones
15. Birthplace Cecil Co., Md.

16. Informant John W. Garner
Address Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 3, 1946 (month) (day) (year)
Cemetery or crematory Quarryville
Location Quarryville Lancaster Co., Pa.
18. Funeral director L. A. Patterson & Son
Address Perryville, Md.

19. Dec. 2 1946 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30 1946 at 2 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1946 to Nov. 30 1946 and that I last saw h.e alive on Nov. 29 1946

| Immediate cause of death | DURATION |
|---|---|
| Cardiac failure | |
| Due to Met. g.l. Ca. | |
| into lungs | |
| Due to Primary Cancer | |
| of Breast | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address P. O. Port Deposit Md. Date signed 12-1-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING (M)

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2 X

## CERTIFICATE OF DEATH

P

110182

Reg. Dist. No.

1. PLACE OF DEATH:
County Belair Harford Nursing Home
City or town Belair Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Belair
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Della. LAMBERT

3.(b) Social Security Number

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband or wife John P. Lambert
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 17 - 1869

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 77. | 2. | 15 | ..... hrs. ..... min. |

9. Birthplace Carrollton Indiana
(Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business
FATHER 12. Name Thomas J. Gregary
13. Birthplace Uniontown Kentucky
MOTHER 14. Maiden name Mary E. Drumm
15. Birthplace Indiana
16. Informant John P. Lambert Jr.
Address 2622. Fleet St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4 - 1946 (month) (day) (year)
Cemetery or crematory Lorraine Cemetery
Location Baltimore Md
18. Funeral director Mamie Cook Dyer
Address 1600 W. North Ave
19. 11/4 (Date rec'd by registrar) 19 46 D. L. Hedrick Registrar

1-35

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 - 19 46 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 - 1946, to Nov 1 1946
and that I last saw her alive on Oct 26 - 1946

| Immediate cause of death | DURATION |
|---|---|
| Carcenoma of Colon | 7 |
| Due to | |
| Due to | |
| Other conditions None | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Willard P Hudson M. D. or other
Address Forest Hill Md Date signed 11-1-46

VS A15 9-45-25M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF 2

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

## CERTIFICATE OF DEATH

11100

Reg. Diat. No. 185-0

**1. PLACE OF DEATH:**
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 yrs.
Hospital, Institution, or street address where death occurred:
Erie & Juniata Sts.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Erie & Juniata Sts
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** WALTER LEE MARTIN Sr.

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Separated |

6.(b) Name of husband or wife Emma V. Martin
6.(c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) Sept. 9, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | | 26 | hrs. min. |

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual occupation Retired Rail Road
11. Industry or business —

FATHER
12. Name Samuel H. Martin
13. Birthplace Maryland

MOTHER
14. Maiden name ?
15. Birthplace Maryland

16. Informant W. Lee Martin (Son.)
Address 611 Chem St. Havre de Grace
17. Burial, cremation, or removal. Which? Burial Date thereof 11/8/46 (month) (day) (year)
Cemetery or crematory Mt. Zion
Location Churchville Md.
18. Funeral director Pennington & Son
Address Havre de Grace
19. Nov. 6 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

**MEDICAL CERTIFICATION** approx

20. DATE OF DEATH Nov. 4 1946, at 11 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

| | DURATION |
|---|---|
| Immediate cause of death Cerebral Hemorrhage | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. W. Ramsey M.D.
Exp. Medical Examiner C. D. or other
Address Aberdeen, Md. Date signed Nov. 6, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

1-35

WITHIN CORPORATE LIMITS OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

Reg. Dist. No. 11101 - 185 - 2

**1. PLACE OF DEATH:**
County: Harford
City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 hrs.
Hospital, institution, or street address where death occurred: Harford Memorial Hosp.
How long in hospital or institution? 2 1/2 hr

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)
State: Md County: Harford
City or town: Dublin (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

**3.(a) FULL NAME:** FRANK Thomas Poole

**3.(b) Social Security Number:** No

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6.(b) Name of husband or wife: Nor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 8, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 8 | ..... hrs. ..... min. |

9. Birthplace: Forrest, Md (Town, county, and state)
10. Usual occupation: New born
11. Industry or business:

FATHER
12. Name: Thomas O. Poole
13. Birthplace: Alleghany Co., N.C.

MOTHER
14. Maiden name: Ruby Wagoner
15. Birthplace: Alleghany Co., N.C.

16. Informant: Thomas O. Poole
Address: Whitford, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20 1946 (month) (day) (year)
Cemetery or crematory: Dublin L. M. Cem
Location: Harford Co. Md.

18. Funeral director: W. L. Bailey
Address: Darlington Md

19. 11-19-1946 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 17 1946 at 1.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 17 1946 to Nov 17 1946 and that I last saw him alive on Nov. 17 1946

| Immediate cause of death | DURATION |
|---|---|
| Respiratory failure | |
| Due to: Bronchopneumonia | 2 days |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Dudley Shilby M.D. M. D. or other
Address: Harford Mem. Hosp. Date signed 11/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

I-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-C)

## CERTIFICATE OF DEATH

11102

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 days
Hospital, institution, or street address where death occurred:
Harford Memorial Hosp.
How long in hospital or institution? 50 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, the residence of mother)
State Maryland County Cecil
City or town Perryville, Md., Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Port Deposit Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martin Lee Price

3.(b) Social Security Number 214-16-6935

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

6.(b) Name of husband or wife Myrtle Lindell Price
6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1905

8. AGE: Years 41 | Months 3 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual occupation Cabarer

11. Industry or business B. & O. R.R.

FATHER
12. Name William O. Price
13. Birthplace Harford Co., Md

MOTHER
14. Maiden name Viola B. Gillert
15. Birthplace Harford Co., Md.

16. Informant Myrtle L. Price
Address Perryville, Md. Rural

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Nov. 25 1946
(month) (day) (year)
Cemetery or crematory Bethel
Location Chesapeake City, Md., Rural

18. Funeral director Lee A. Patterson & Son
Address Perryville, Md.

19. 11-23 1946 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1946 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/2 1946 to 11/22 1946 and that I last saw h... alive on 11/22 1946

| | DURATION |
|---|---|
| Immediate cause of death: Fracture Right Femur | |
| Fracture left Tibia & Fibula | |
| Due to: Open Operation & Reaction | |
| Due to: Post Operative Shock | |
| Cerebral Embolus | |
| Other conditions: Automobile accident: Struck by automobile, while intoxicated. D.W.I.R. | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of October 2nd 1946.
Where did injury occur? Highway between Aiken & Port Deposit, Maryland.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury struck by automobile. Injured at work?

23. SIGNATURE Charles J. Foley M.D.
M.D. or other
Address Havre de Grace, Md. Date signed 11-23

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

(486) 11103

Reg. Dist. No. 1821

1. PLACE OF DEATH: Harford
County
City or town Dublin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Dublin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Alma M. Ragar

3.(b) Social Security Number No

4. Sex Female | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife No

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1939

8. AGE: Years 7 | Months 9 | Days | If less than one day hrs. min.

9. Birthplace Harford Co. Md.
(City, county, and state)

10. Usual occupation School Child

11. Industry or business School

FATHER 12. Name Garland Ragar

13. Birthplace Logan, Ky.

MOTHER 14. Maiden name Mary Hughes

15. Birthplace Harford Co. Md.

16. Informant Mrs. Garland Ragar

Address Darlington, Md.

17. Burial (Burial, cremation, or removal) Date thereof Nov. 23, 1946 (month) (day) (year)

Cemetery or crematory Ascension Cem

Location Harford Co. Md.

18. Funeral director H. S. Bailey

Address Darlington, Md.

19. Nov. 22, 1946 (Date rec'd by registrar) M. G. Kirk Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1946, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13, 1946, to Nov. 24, 1946 and that I last saw h-- alive on Nov 5, 1946

| Immediate cause of death | DURATION |
|---|---|
| Sarcoma of uterus | 1 yr |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations Sarcoma of uterus

Date of op. 8-19-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Gallion M. D. or other

Address Darlington Md. Date signed 11-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

2-20

2-1820-2-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160)

## CERTIFICATE OF DEATH

11104

Reg. Dist. No. 165

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 10 hrs. 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State — County —
City or town — (Perryman)
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Baby Raines

3.(b) Social Security Number —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| m - | White | Single |

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1946

8. AGE: Years — Months — Days — If less than one day: 10 hrs. 15 min.

9. Birthplace Havre de Grace, Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Charles A. Raines
13. Birthplace S. Dak.

MOTHER
14. Maiden name Mildred Williams
15. Birthplace Ark.

16. Informant Mr. Charles A. Raines
Address Co. L. 10th Bnt. A.P.G. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11, 1946 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace, Md.

18. Funeral director R. Madison Mitchell
Address Havre de Grace Md

19. Nov 11 1946 (Date rec'd by registrar) A. L. Levis M. D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1946, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10 1946, to Nov. 10 1946
and that I last saw h[illegible] alive on Nov. 10, 1946

| Immediate cause of death | DURATION |
|---|---|
| Prematurity | |
| Due to: Premature Separation | |
| Due to: Placenta | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Lewis Mitchell M. D. or other
Address Havre de Grace Date signed 11/10/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

(93d) * 11105

Reg. Dist. No. 1810

**1. PLACE OF DEATH:**
County: Harford
City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

**3.(a) FULL NAME:** Robert H. Ross

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6.(b) Name of husband or wife: Margaret E. Russell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9 - 1864

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 6 | | hrs. ..... min. |

9. Birthplace: Lancaster Co. Pa
(Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business: Retired
FATHER 12. Name: Reason Ross
FATHER 13. Birthplace: Penn.
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Penn.
16. Informant: Mrs. William J. Power Sr.
Address: Joppa. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 30. 1946 (month) (day) (year)
Cemetery or crematory: Presentia
Location: Perryman Md.
18. Funeral director: Henry Tanning Sons.
Address: Aberdeen Md.
19. Nov 30 1946 (Date rec'd by registrar) Nellie F. Riley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 1946 at 11:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 1946, to Nov 27 1946, and that I last saw him alive on Nov 27 1946.

| | DURATION |
|---|---|
| Immediate cause of death: Cerebral Thrombosis | |
| Due to: Chronic Myocarditis | |
| Due to: Acute Myocarditis | |
| Due to: | |
| Other conditions: Cardiac Failure | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D.
M. D. or other
Address: Havre de Grace Md. Date signed 11/30/46

(M)
(I)
MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS A15 9-45-15M

2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

## CERTIFICATE OF DEATH

*11106

Reg. Dist. No. 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-10M

**1. PLACE OF DEATH:**
County Harford
City or town Street Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Harford
City or town Rural - Street
(If outside city or town limits, write RURAL and give nearest town)
Street No. Emory Church
(If rural, give LOCATION)
2.(a) If veteran, name war No

**3. (a) FULL NAME** Arthur J. Stevens

**3. (b) Social Security Number** No

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Mary Stevens Dead
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 26, 1946
8. AGE: Years 88 Months 3 Days 5 If less than one day ..... hrs. ..... min.
9. Birthplace: Harford Co, Md. (Town, county, and state)
10. Usual occupation: Black Smith
11. Industry or business: Wagon work
FATHER 12. Name: Robert Stevens
FATHER 13. Birthplace: Harford Co, Md.
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace
16. Informant: Mrs. Roy Stevens
Address: Street, Md. Rural
17. Burial (Burial, cremation, or removal) Date thereof Nov. 3 1946 (month) (day) (year)
Cemetery or crematory: Bakers Cem.
Location: Harford Co, Md.
18. Funeral director: H. L. Bailey
Address: Darlington, Md.
19. Nov. 9 1946 (Date rec'd by registrar) M. W. Kirk Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1- 1946, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 2- 1944 to Nov 1- 1946 and that I last saw h--- alive on Oct 31- 1946

| Immediate cause of death | DURATION |
|---|---|
| Hypostatic Lobar Pneumonia | 3 Da |
| Due to Terminating | |
| Due to Cl. Cardio-Vescular disease | 5 yr. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md. Date signed 11/1/46

2-25

2-1820

2-10

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11107

106-P

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Harford

City or town Darlington, Rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Md. County Harford

City or town Darlington, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Laura R. Thompson

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | widowed |

6.(b) Name of husband or wife Isaac Thompson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30 - 1874

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 1 | 23 | hrs. min. |

9. Birthplace York Co. Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Hugh McConkey

FATHER 13. Birthplace York Co. Pa.

MOTHER 14. Maiden name Annie Rooney

MOTHER 15. Birthplace Harford Co. Md.

16. Informant Mrs. Thomas Harkins

Address Darlington, R.D. Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 26 1946 (month) (day) (year)

Cemetery or crematory Southern Cemetery

Location Dublin Md.

18. Funeral director Hubert P. Harkins

Address Delta Pa.

19. Nov. 25 '46 M. A. Kirk (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1946, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1944, to November 23 1946 and that I last saw h... alive on November 23 1946

| Immediate cause of death | DURATION |
|---|---|
| Cerebral embolism | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Cardiff, Md. Date signed 11/24/46

2-25

2-1820-210

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49a

11108

## CERTIFICATE OF DEATH

Reg. Diat. No. 182

**1. PLACE OF DEATH:**

County: Harford

City or town: Rural Bel Air
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Bel Air
(If outside city or town limits, write RURAL and give nearest towo)

Street No.: Bel Air
(If rural, give LOCATION)

2.(a) If veteran, name war: None

**3.(a) FULL NAME:** Mrs. Sarah Frances Todd

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband ~~or wife~~: G. B. Todd

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 13-1865

8. AGE: Years: 91 | Months: 2 | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Van Gilmanton Co. N.C.
(Town, county and state)

10. Usual occupation: At home

11. Industry or business:

FATHER
12. Name: Richard Cheek
13. Birthplace: N.C.

MOTHER
14. Maiden name: Martha Jennings
15. Birthplace: N.C.

16. Informant: Mrs. S. G. Richardson

Address: Bel Air Md. R.F.D. #1 Box 95

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 24-1946 (month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: Near Bel Air Md.

18. Funeral director: Henry Tawney & Sons

Address: Aberdeen Md.

19. 11/23 (Date rec'd by registrar) 1946 Priscilla Linwood Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Nov. 22 1946, at 1:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 1946 to Nov 22 1946 and that I last saw her alive on Nov 22 1946

| | DURATION |
|---|---|
| Immediate cause of death: Cystic Tumor of Abdomen | 4 Mos. |
| Due to: Cancer of ovary | 1 yr. |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations: ~

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. P. Snodgrass M. D. or other

Address: Darlington Md. Date signed: 11/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

## CERTIFICATE OF DEATH

2 ☆ 11109

Reg. Diat. No. 1820

**1. PLACE OF DEATH:**
County: Harford
City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** ELSIE MAE TUCKER

**3.(b) Social Security Number:** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | Single |

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 15, 1876

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 9 | 20 | ..... hrs. ..... min. |

9. Birthplace: Forest Hill, Harford Md.
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business

FATHER
12. Name: Samuel P Tucker
13. Birthplace: Forest Hill, Md.

MOTHER
14. Maiden name: Margaret Grafton
15. Birthplace: Chestnut Hill, Md.

16. Informant: Mrs. Wm. Scarborough
Address: Forest Hill Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 10 1946 (month) (day) (year)
Cemetery or crematory: Centre
Location: Forest Hill, Harford Co. Md.
18. Funeral director: Martin G. Kurtz
Address: Jarrettsville, Md.

19. 11/9 1946 Priscilla Fawcett
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8 1946, at 3:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Fracture of skull Basal | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11/7/46
Where did injury occur? near Forest Hill (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?): Route # 24
Means of injury: Fell out of auto Injured at work? No

23. SIGNATURE: J. W. Lamm M. D.
Asst. Medical Examiner M. D. or other
Address: Aberdeen, Md. Date signed 11/9/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

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